



St. John's Regional Medical Center
St. John's Pleasant Valley Hospital

Members of CHW



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Community Benefit Report 2011
Community Benefit Plan 2012

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REFLECTION

Catherine McAuley, Founder of the Sisters of Mercy (our sister sponsors), called those who follow in her steps to,

“Connect the rich with the poor, the healthy to sick, the educated and skilled to those who lack, the influential to those forgotten, the powerful to the weak, and through this do the work of God on earth.”

EXECUTIVE SUMMARY

St. John's Regional Medical Center in Oxnard and St. John's Pleasant Valley Hospital in Camarillo (together referred to as St. John's Hospitals) are members of Catholic Healthcare West (CHW), a not-for profit corporation founded 25 years ago by several Roman Catholic religious communities.

Together, St. John's Hospitals represent the largest acute care health organization in Ventura County. With over 1900 employees, with primary service areas of Oxnard, Port Hueneme and Camarillo, St. John's also serves all of Ventura County and beyond, including the cities of Ventura, Moorpark, Thousand Oaks and Somis.

The Sisters of Mercy established St. John's Regional Medical Center (SJPMC) (originally called St. John's Hospital) near the coastal plain of Oxnard in 1912. The hospital grew from a six-room wooden structure on a ten acre parcel of land to today's 265-bed facility on a 48-acre parcel of land in northeast Oxnard. Located in a community that has a land use mix of residential, agricultural and industrial, and includes a large Navy base and a vacation harbor area, SJPMC offers comprehensive medical programs and services, including acute physical rehabilitation, cardiac care, cancer care, maternity and childbirth services, orthopedics, and neurology, and is also home to St. John's Cancer Center of Ventura County, St. John's Regional Spine Center, and St. John's Center for Surgical Weight Loss. SJPMC has the only 24/7 Intensivist program in Ventura County for Critical Care.

More inland and in the shadow of the Santa Susana foothills, St. John's Pleasant Valley Hospital (SJPVH) was founded in 1974 by a group of Camarillo community leaders and physicians who believed that the community needed a hospital of its own. Licensed for 180 beds, SJPVH has the only hospital-based hyperbaric medicine and wound healing center in western Ventura County and the only Sub-Acute facility in Ventura County. St. John's Pleasant Valley Hospital offers an array of medical programs such as orthopedic surgery, neurology, emergency care, critical care and other services.

St. John's hospitals continue the legacy of healing and community service in the Catholic social tradition. Many of the outreach/community benefit programs at St. John's were initiated by the Sisters of Mercy and one sister sponsor continues to work in the Community Education Department today.

In response to those issues identified our 2009 Community Needs Assessment (which is posted on the St. John's Web page), St. John's continues its commitment to meet the health care needs of those who are un/under insured, with foci of: Diabetes Hospital Admission/Readmission, Diabetes Case Management Outreach, Community Immunizations,

Youth Obesity Prevention, Comprehensive Perinatal Services Program (CPSC) of Prenatal Care, Senior Health/Wellness. This year we also added: a Chronic Disease Self Management Program (CDSMP) and a Congestive Heart Failure (CHF) Readmission Reduction program.

CDSMP consists utilizes an evidence based proven outcome Stanford model of workshop given two and a half hours, once a week, for six weeks, attended by people with different chronic health problems. The workshops are facilitated by two trained leaders. Subjects covered include: 1) techniques to deal with problems such as frustration, fatigue, pain and isolation, 2) appropriate exercise for maintaining and improving strength, flexibility, and endurance, 3) appropriate use of medications, 4) communicating effectively with family, friends, and health professionals, 5) nutrition, and, 6) how to evaluate new treatments. Classes are highly participative, where mutual support and success build the participants' confidence in their ability to manage their health and maintain active and fulfilling lives.

Diabetes Hospital Admission/Readmission Reduction program aims at reducing the complications and associated hospital readmissions of community members with type 2 diabetes, by identifying and recruiting an annual cohort of 50 – 75 community members into the Hospital Admission/Readmission Reduction (HARR) Program and providing enhanced diabetes-related preventative and screening services to program participants.

Diabetes Case Management Outreach is intended to assist community members without financial means or with other barriers access and follow-up care, with information, education, treatment, and self-management tools to manage their chronic disease. Designed to benefit those individuals with diabetes who are not able to participate in the Hospital Admission Readmission Reduction Program (above) and those participants who need additional case management support, this case management outreach program acts as a “safety net” in providing a variety of free services and connects those in need with various community health resources.

CPSC Prenatal Care program (named Healthy Beginnings) provides bilingual and bicultural prenatal healthcare services, including screenings and education for low income un/under insured women. Program goals and activities include: avoiding low birth weight, identifying and referring for treatment gestational diabetes, breast feeding soon after birth, relational issues arising from the pregnancy, hospital pre-registration and referral for state insurance programs as needed.

Community Immunizations in our Primary Service Areas were enhanced through our Shots for Kids and Adults program designed to ensure up-to-date immunization compliance for school aged children and their family members. St. John's held 31 Shots for Kids and Adults clinics-- four of them using the Mobile Screening Vehicle. In all during FY 2011 we gave 2,443 immunizations compared to 1,959 in 2010 (a 20% increase in community immunizations)..

Senior Health/Wellness is addressed through our Senior Health Connection which consists of several programs that aim to provide seniors with tools to improve their health and wellness. We offer: Energizer's Walking Program, English- and Spanish-language diabetes support groups, Spanish-language People with Arthritis Can Exercise (PACE) classes, flu and pneumonia immunizations clinics, mature driver safety classes, Health Insurance Counseling and Advocacy Program, wellness lectures and classes, and wellness clinics offered at three senior centers in Oxnard. Blood pressure and blood glucose screenings are offered during the wellness clinics and at the Energizer's Walking Program. In addition, hemoglobin glucose (HbA1C) screenings are offered to participants who have diabetes. Through the Senior Health Connection

Program, St. John's offers blood pressure screenings at the Pleasant Valley Senior Center and at Alma Via in Camarillo, and in senior health expositions and health fairs in the community.

CHF Readmission/Reduction is a new HARR program utilizing the Congestive Heart Active Management Program (CHAMP®) from the Mercy General Hospital, Sacramento Mercy Heart & Valve Institute. This is evidence based and proven comprehensive program to assist those who have the condition known as congestive heart failure (CHF). CHAMP® involves you in your recovery. Through regular phone interaction (Spanish or English) CHAMP® will help recently discharged patients and their family members better understand CHF so as to empower them to manage this condition in order to improve the quality of their lives, increase interactions with their physician and avoid unnecessary hospitalizations.

In FY2011, St. John's unsponsored community benefit expense, excluding the unreimbursed cost of Medicare, totaled \$23,697,774 at St. John's Regional Medical Center and \$6,102,412 at St. John's Pleasant Valley. Including the cost of Medicare, the totals for each hospital were \$45,518,874 and \$18,779,159 respectively. The combined total of unsponsored community benefit expense totaled \$64,298,033.

MISSION STATEMENT

ST. JOHN'S HOSPITALS' MISSION

As members of Catholic Healthcare West, (CHW) St. John's Hospitals are committed to the Mission of CHW. That Mission is:

Catholic Healthcare West and our sponsoring Congregations are committed to furthering the healing ministry of Jesus. We dedicate our resources to:

- Delivering compassionate, high-quality, affordable health services;
- Serving and advocating for our sisters and brothers who are poor and disenfranchised; and
- Partnering with others in the community to improve the quality of life.

St. John's Hospitals Vision:

We are a vibrant, regional healthcare system known for service, chosen for clinical excellence and great patient experiences, standing in partnership with patients, employees, volunteers and physicians we are dedicated to improve the health of the people of Ventura County.



Catholic Healthcare West Our Mission, Vision, and Values

Our Mission

Catholic Healthcare West and our Sponsoring Congregations are committed to furthering the healing ministry of Jesus. We dedicate our resources to:

- delivering compassionate, high-quality, affordable health services;
- serving and advocating for our sisters and brothers who are poor and disenfranchised; and
- partnering with others in the community to improve the quality of life.

Our Vision

A growing and diversified health care ministry distinguished by excellent quality and committed to expanding access to those in need.

Our Values

Catholic Healthcare West is committed to providing high-quality, affordable health care to the communities we serve. Above all else we value:

Dignity – Respecting the inherent value and worth of each person.

Collaboration – Working together with people who support common values and vision to achieve shared goals.

Justice – Advocating for social change and acting in ways that promote respect for all persons and demonstrate compassion for our sisters and brothers who are powerless.

Stewardship – Cultivating the resources entrusted to us to promote healing and wholeness.

Excellence – Exceeding expectations through teamwork and innovation.

ORGANIZATIONAL COMMITMENT

Despite different beginnings, both St. John's hospitals have from their founding held to the notion of community service as the guiding principle in what they do. With new hospital leadership in 2011 a revitalized vision of offering Loving Care as a Ministry of Healing to our patients and communities has taken hold and influences all that we do. This new breath of life in our ministry has mixed well with our heritage of Catholic social tradition from our Sisters of Mercy sponsors and Community Leadership. With quarterly reports to the Community Board, active oversight by the Community Board's Community Relations/Community Benefits Committee, regular funding for programs dedicated to those in need from the St. John's Healthcare Foundation, and most importantly, volunteering by hospital staff for specific community benefit events, organizational commitment can be found at every level of the organization.

Newly chartered in 2011 the Community Board's Community Relations/Committee Benefits Committee makes the annual recommendations to CHW for the local hospitals' CHW Grants Program. For fiscal year 2011-11 those grants were as follows:

Assistance League of Ventura County	\$25,000
Boys & Girls Club, Camarillo	\$8,000
Camarillo Hospice	\$10,000
Foodshare	\$13,750
Livingston Visiting Nurse Assoc.	\$10,000
Mercy Housing--Oxnard	\$11,300
Promotoras y Promotoras Foundation	\$15,000
Rescue Mission Alliance—Lighthouse Shelter	\$15,000
Salvation Army Port Hueneme Free Clinic	\$25,000
Servants of Mary, Ministers to the Sick	\$13,161
Total	\$146,211

With the Vice President of Mission Integration as the executive liaison, the Committee in the year to come will continue to grow through: monitoring community benefit/outreach activities and opportunities that are consistent with the hospitals' strategic plan in addition to consideration of the core principles from the Association for the Advancement of Community Benefit.

In addition to these commitments of time, this past year, the St. John's Healthcare Foundation allocated funds raised by the Latino Healthcare League for the purchase of the St. John's Mobile Screening Unit.



(Mobile Unit & staff at free community health screenings.)



(As 'Health Sponsor' of the Ventura County Fair.)

This gives community outreach activities better mobility, visibility and raises a host of potential new programs/partnerships for the years to come.

CHW's Commitment

CHW's commitment to the area is evidenced by the CHW Community Investment Program loan for community redevelopment in Ventura County. This multi-million dollar project by Cabrillo Economic Development Corp. (a not for profit developer) will provide 66 farm worker families with affordable housing using "Green" building on the site of a former farm labor camp.

ST. JOHN'S ORGANIZATIONAL COMMITMENT OVERVIEW

St. John's Hospitals provide outreach and community services that demonstrate our commitment to the mission and history of the founding Sisters of Mercy in accordance with the Catholic Social Tradition of service. This is accomplished through our extensive community benefit programs, which provide free or low cost screenings, tests and/or treatment promotes health and community wellness in response to identified community needs. The hospitals' charitable resources are dedicated to delivering community benefit through affordable healthcare services, offering outreach and education, providing focused services that address identified needs, and improving the quality of life for communities with disproportionate unmet health needs throughout Ventura County.

St. John's Community Board's Community Relations/Community Benefits Committee (CR/CBC)

St. John's has a dedicated team of hospital leaders, St. John's Community Board members, and key community stakeholders who support the planning, implementation, evaluation, and enhancement of community benefit efforts. The CR/CBC has formalized its process through a comprehensive charter which calls out its responsibility of oversight for all community benefit programs. The CR/CBC also participates in establishing priorities based on community needs, hospital resources, CHW's Vision 20/20 plan and our strategic plan. The CR/CBC then evaluates progress toward agreed upon program goals. The CR/CBC also plays an important role in identifying community partners to collaborate with in an effort to address identified needs. The link to the Community Board is sustained by members of the CR/CBC reporting Community Benefit activities to the entire Community Board monthly. This direct line of communication serves to focus community benefit efforts in supporting St. John's ongoing mission of healing and our strategic plan. The CR/CBC offers guidance in program formulation and is pivotal in decision making regarding new programs or terminating existing programs on a values based decision making process.

Appendix A provides a complete list of the current (2011-12) Community Board noting those who are CR/CBC members.

Appendix B contains the CR/CBC 2010-11 Charter (currently in revision for 2012 involving member names only).

COMMUNITY

Definition of Community

Community is defined as the resident population within the hospitals' service areas. St. John's Pleasant Valley Hospital in Camarillo and St. John's Regional Medical Center in Oxnard serve all of Ventura County. The primary service areas and associated zip codes are as follows:

Camarillo 93010
Camarillo 93012
Oxnard 93030
Oxnard 93033
Oxnard 93035
Port Hueneme 93041

Under the guidance of the Community Relations and Benefits Committee of the Community Board, St. John's has shifted from concentrating only on the needs of its primary service areas,

to a wider area that takes into account the needs throughout the region of Ventura County, with particular attention to the disproportionate unmet healthcare needs of vulnerable populations throughout the county. Data cited in the Description of the Community section below is drawn from our 2009 Community Needs Assessment, which is available on the St. John's webpage at http://www.stjohnshealth.org/Who_We_Are/Serving_the_Community/201764.

Description of the Community

- Population – among the six communities that make up St. John's primary service area, the population totals 258,141 residents.
- Age Groups – 29.8% of the area's population is under age 18. Senior citizens make up 10.3% of the population. This is consistent with the county as a whole, 26.2% and 11.1% respectively.
- Race/Ethnicity – half of the population in the service area is Latino Caucasian (50.9%), as opposed to 37.2% for the county. Non Latino Caucasian still makes up the majority population for Ventura County at 52.3%. Oxnard has the highest percentage of Latino residents (70%). All cities in the service area have seen a decrease in Caucasian residents and an increase in the Latino population.
- Adult Education – overall, 17.8% of the adults in the service area have less than a high school education. Areas of Oxnard show 40% or more of the adults have less than a high school education.
- Poverty Status – the poverty rate for the service area is 12.1%; however, the poverty rate increases to up to 18% in areas of Oxnard. The poverty rate for Ventura County is 8.7%.
- Unemployment and Income – among the cities in the service area, the unemployment rate is on the rise from 3.4% in 2000 to 9.5% in 2009. The median household income in Oxnard is \$55,716 versus \$78,677 in Camarillo, and \$72,762 for the county.
- Public Assistance – caseload comparison for various public assistance programs in the county are also up. The number of CalWorks cases increased from 5,835 in December 2007 to 6,551 in December 2008 (a 12.3% increase). During this same time period, the number of people on food stamps also increased from 14,225 to 18,095 (27.2% increase). In terms of MediCal, the percent increase was not as high (4.6%), from 43,756 to 45,787.
- Primary Language and Linguistic Isolation – English and Spanish are the primary languages spoken in most households within the service area. One-third (33.0%) of the county population indicate they speak a language other than English at home, compared to 44.5% in the service area and 67.4% in Oxnard.
- Birth Characteristics – there were 5,204 live births in the service area in 2006. Teenage mothers accounted for 12.4% of births. Of the total number of births, 6.5% did not receive prenatal care until the third trimester or not at all.
- Lack of Insurance – 24.6% of the households interviewed indicated that they did not have any type of insurance coverage.
- The hospitals serve a federally-designated medically underserved area.

Community Needs Index (CNI)

The Community Needs Index (CNI) is a tool developed by Catholic Healthcare West that accurately pinpoints communities in St. John's service areas with the greatest barriers to healthcare access. This tool uses socioeconomic and hospital utilization data to provide an "at a glance" view of disproportionate unmet healthcare needs in a geographic area, and correlates that need with hospitalization for preventable health conditions. Within St. John's primary

service area, the zip code with the greatest need as identified by the CNI is 93030. This validates the findings and needs identified in the 2009 Community Needs Assessment (refer to CNI attached as Appendices C & D).

The community is also served by Community Memorial Hospital and the Ventura County Medical Center in Ventura, Los Robles Regional Medical Center in Thousand Oaks and Simi Valley Adventist Hospital in Simi Valley.

COMMUNITY BENEFIT PLANNING PROCESS

Community Needs Assessment

Senate Bill (SB) 697, the Community Benefit Legislation, passed in 1994. This legislation encouraged not-for-profit hospitals to consult with community groups and local government officials to identify and prioritize the needs of their communities. Additionally, it paralleled St. John's commitment to assess the health status of its community. In keeping with SB 697, and our own desire to serve our community, St. John's conducts a Community Needs Assessment (CNA) of the community every three years to determine the greatest unmet healthcare needs, in our service area, with the most recent completed during 2009.

As part of the community needs assessment process, St. John's Hospitals collaborated with other healthcare organizations in Ventura County to form the Community Needs Assessment Collaborative Group (CNACG). The main purpose of CNACG was to assess the healthcare needs of Ventura County residents by identifying the existing community needs. The CNACG provided the mechanism to bring representatives from local hospitals and healthcare agencies together to review and discuss the needs in the county. The CNACG members jointly developed survey questions, selected the methodology, and shared the cost of the survey administration and survey analysis.

A telephone survey was determined to be the most cost effective, time-efficient, and successful way to survey a large population. The Innovative Research Group in Thousand Oaks was contracted to provide project oversight, help update the survey tool, conduct the survey, and analyze the data.

The principal purpose of the survey was to collect primary data from residents of Ventura County by conducting a scientific survey of county residents. Access to healthcare services, availability of services, and concerns of residents about their healthcare and costs of services were some of the issues examined to determine the healthcare needs and preferences of Ventura County residents.

The survey methodology of the 2009 CNA is consistent with the scientific methodology that was used for previous surveys conducted in 1995, 1997, 2000, 2003, and 2006. In all these surveys, standard and professionally recognized survey methodology was utilized to perform the required tasks. To select a truly representative sample of the residents of Ventura County, a combination of the stratified random sampling and the simple random sampling methods were used. The population of Ventura County was divided into twenty-three zip code areas. Within each zip code, the Innovative Research Group used a computer program to select a representative sample of that zip code. A stratified random sampling method was used to select a representative sample for each zip code. The sample reflected the diversity of the population for each city or zip code area. The respondents for each zip code were selected by using

appropriate statistical methods. The desired margin of error was approximately five percent. From April 12 to May 15, 2009, the survey team administered the telephone interviews by using a computer assisted telephone interviewing procedure. In total, 12,800 phone calls were made resulting in 1,014 completed surveys, which represent a 7.9 percent cooperation rate. All interviews were conducted by bilingual staff.

The result of the 2009 CNA survey presented a comprehensive picture of the healthcare issues facing Ventura County. Healthcare topics such as access to different resources, availability of services, and concerns about costs of services were some of the issues examined to determine the healthcare needs and preferences of Ventura County residents. The CNA identified the following top five unmet needs:

- AVAILABILITY, ACCESS AND COST of healthcare services, with growing community concern for the numbers of uninsured and underinsured in Ventura County
- CHRONIC DISEASE MANAGEMENT, PREVENTION, AND EDUCATION with emphasis on obesity, diabetes, HIV/AIDS, heart disease, and cancer (including breast, cervical and prostate cancer)
- WOMEN'S HEALTH SERVICES including perinatal access and education for low-income women (particularly women of Latino/Hispanic ethnicity), mammography, and Pap smears
- ADULT AND CHILD IMMUNIZATIONS (ages 0 – 2; Hepatitis A and B; flu and pneumonia shots)
- CHILDREN AND YOUTH HEALTH AND WELLNESS, with concern for obesity, smoking, dental health, alcohol use, teen pregnancy, asthma, environmental and safety issues.

In previous surveys, the following issues were identified as potential healthcare problems: the cost and availability of healthcare services; insurance problems and HMO authorization issues; location and transportation problems; childcare and eldercare problems; language barrier; and the hours that the healthcare provider is open to see patients. Using results of the 2009 survey, we have calculated a series of “healthcare difficulty indices.” Based on the results of the 2009 survey, the top three healthcare services with the highest difficulty indices were:

1. Cost of services (60.7%),
2. Insurance problems (47.6%),
3. Availability of service (26.4%).

Compared to the 2006 survey the “hours that the healthcare provider is open to see patients” significantly deteriorated with a 5.6% increase, followed by the “availability of service” which showed 4.48% increase for the same time period. There was a significant deterioration in the healthcare difficulty index associated with the cost of service and with the insurance problems index.

Un- and Under Insured

The recession of 2009 and following world-wide financial crises have taken their toll at the local level. In the last three years, between 2000 and 2009, insurance problems showed an increase of 18.3%, exhibited the worst change, and the cost of service, with an increase of 16.7%, had the second worst deteriorating change in the healthcare difficulty index. The CNA notes that the percentage of children who are covered by any type of health insurance dropped by 15.3%. Both the short- and the long-run trend indicate that there was a significant decline in the percentage of children who are covered by any type of health insurance. Similarly, in the long-run period of 2000 – 2009, there was a significant decrease (24.7%) in the percentage of residents who stated that they were covered by private insurance. At the same time, there was

a significant increase in the percentage of the residents who stated that they were covered either by MediCal (9.8%) or Medicare (5.1%), yet the percentage of residents who stated that they were covered by Healthy Families decreased by 7.7%. Most significant is the fact that one quarter (24.6%) of respondents indicated that they do not have any type of health insurance coverage for the adult members of their household. Both the short- and the long-run trend indicate that there has been a significant decline in the percentage of Ventura County residents covered by any type of health insurance. From 2006 – 2009, there was a 9.1% decline in the percentage of Ventura County residents covered by any type of health insurance. This index showed a 16.0% decline for the long run from 2000 – 2009. This gap in insurance coverage, both for children and adults, is one of the top healthcare concerns in Ventura County. The 2009 CNA survey also indicates that the top three healthcare services with the highest accessibility ratings were hospital care (92.7%), followed by basic primary care (91.3%), and dental healthcare (90.4%). Community Benefit planning has thus been focused on meeting the needs of those who are un/under insured outside the hospital setting. For 2012, the focus will take a new turn to Community Wellness and Prevention.

Heart disease remains the number one cause of death in the county, followed by different forms of cancer. In almost all types of cancers, the rates for Latinos are considerably lower than that for Caucasians (non Latino). The death rate due to breast cancer is comparatively lower in Ventura County than the State of California. The rates for colorectal cancer between the years 2000 to 2006 suggest that it is mildly declining both for the State and the county—this becomes quite apparent during the latter three years of the period of our observation. This is hopeful news as it suggests that better preventive care may be helping to reduce unnecessary death due to colon cancer.

Compared with other ethnicities, the number of Latinos with diagnosed diabetes mellitus is much higher in the 18 – 44 age group. Rates are also high among African-Americans in the county. The study indicates that early detection and education for developing healthy living habits at young ages are the most important steps to consider in preventing and aiding with management of diabetes. Nationwide, the problem of obesity and the rise of diabetes, not only among adults but also in children, has been a highly publicized public health concern.

Preventive Medicine

Among female respondents, while about one out of twelve (8.3%) indicated that they are not aware of cancer screening procedures such as breast exam or mammogram, about nine out of ten (89.5%) said that they are aware of such procedures. Compared to the 2000 survey, there is a significant decline (5.0%) in the percentage of women who said that they or a member of their household had received a clinical breast exam or mammogram. Compared to the 2006 survey, there is a significant increase (7.8%) in the percentage of women who said that they or a member of their household had received a pap smear. However, a reverse pattern is observed for the long-run period of 2000 to 2009. During this time period, there is a significant decrease (11.0%) in the percentage of women who said that they or a member of their household had received a pap smear.

From 2000 to 2009, there was a significant increase in the percentage of residents who had been diagnosed with cervical/uterine cancer (8.0%) and skin cancer (5.3%). On the other hand, the percentages of respondents diagnosed with prostate cancer and colon cancer decreased by 8.8% and 7.0%, respectively. The lack of preventive services has a disproportionate impact on those who earn less, with the \$15,000 to \$25,000 and \$25,000 to \$50,000 earners, the working poor, being the most impacted by lack of access to preventive services.

Respondents were almost equally split in regard to the flu vaccination. While 48.0% of respondents indicated that they had a flu shot, almost the same percentage (49.8%) stated that they did not have a flu shot in the past twelve months. Both the short- and the long-run trend indicate that there was a significant increase in the percentage of Ventura County residents who had flu shots during the last twelve months. From 2000 to 2009, there was a 5.8% increase in the percentage of Ventura County residents who had flu shots.

Perinatal Needs

The birth rate in recent years (2000 to 2007) has been at a stable rate of 14 to 15 per thousand people in the county. In 2007, there were 1,150 mothers who fell in the category of teen mothers, 19 years of age or younger. The total number below 18 years of age (17 or younger) is about 415. Out of 1,150 total teen births, 920 identified themselves as Latino. Also, 351 out of the total number of 415 representing total teen births for girls age 17 or younger are Latino. These numbers reflect a significant social and economic impact on the well-being of these mothers and their children, at present as well as for a long time to come.

Ventura County shows a lower rate of low birth weight (LBW) than the state in all the mentioned years (2001 to 2007) except 2004. LBW is associated with a number of health issues in children, which can continue throughout their lives. Latinos and African-Americans have the lowest rate of prenatal care among all the ethnicities in the county. A number of cities in the western part of the county show a lower first trimester prenatal care amount relative to the eastern part of the county. Furthermore, teen mothers have the greatest problem in taking good care of themselves and their children in regard to starting their prenatal care in a timely manner. Teen counseling that provides education and finds creative ways of helping these young mothers is of great importance.

Obesity

Obesity among low income Ventura County youth continues to grow; particularly in children between the ages of 5 and 19, exceeding both national and California percentages, i.e., 22.7% of low income Ventura County children ages 5 – 19 are overweight. The study also indicates that the trend of the last decade shows a big gap between the goal rate of obesity set for 2010 and current rates. It also shows that in the case of children of lower income, the trend worsened during recent years. Further study is needed to identify possible underlying causes, but developing healthy habits, including sound nutrition, refraining from smoking, and physical activity or children are key.

Ecological Issues

Air quality depends on a variety of issues which are directly related to our way of life, consumption and production (particularly production of agricultural products that use various kinds of chemicals in the production process), traffic congestion, increases in population, and many other factors. Among the major crops, strawberries and lemons use a large amount of toxic chemicals every year. Given the fact that these two crops are the most important crops in Ventura County, jointly accounting for more than 85% of the top five crops, it is not surprising that the use of pesticides in the county has increased over the last decade, reaching nearly 70,000,000 pounds of pesticide used per year. Bearing in mind that the pollution from using pesticides accumulates over time, the increase brings an important issue that, if over looked, may cause negative health consequences in the years ahead. In addition to pesticide use, population growth and vehicle use measured by vehicle miles traveled (VMT) have also increased. The result is that, with the exception of Ojai, the trend for this period of time (2000 to 2007) shows the quality of air worsened in Ventura County. The other clear deduction is that the

air quality is much worse in some places than others. The information presented in this study clearly shows that people with lower income are more likely to be negatively affected by an environmental decay. This suggests that there is a significant problem with environmental justice in our county.

COMMUNITY BENEFIT PLANNING PROCESS

The needs identified in the Community Needs Assessment, St. John's strategic plan, and CHW's Horizon 2020 strategic plan yielded this Community Benefit Plan, and guide St. John's hospitals in our ministry of healing to the community. In fiscal year 2011, our CR/CBC Team included St. John's Community Board members, John Ford MD, St. John's Mission Integration Department, and St. John's Community Health Education Department staff members. This team analyzed the data from the CNA to determine top needs on which to focus our resources and energy. Based on these findings, measurable objectives were defined, and where appropriate, additional partners in the community were identified with whom St. John's could seek to collaborate.

Timeline

August – September 2010 Community Board, Mission leadership, Community Education staff, and medical staff reviewed fiscal year 2011 outcomes and plans for service area, formulated objectives, and implemented Community Benefit Plan update.

August – October 2010 Top healthcare priorities reviewed by Mission Leadership, medical and other staff, community healthcare workers and community members and agencies.

November 2011 Community Benefit Plan completed and approved by St. John's executive leadership and community board of directors.

November 2011 Community Benefit Plan forwarded to CHW corporate office and Office of Statewide Health Planning and Development.

December 2011 the Community Benefit Report & Plan posted on the St John's website including a request for input from the community

February 2012 The 2012 Community Health Needs Assessment process begins.

June 2012 The 2012 Community Health Needs Assessment completed

Participants

Input on specific issues—needs currently being met, types of community members served, and special needs groups—was sought from representatives from the following areas:

- Hospital Administration
- St. John's Sister of Mercy Sponsors
- St. John's Community Board
- Community Health Education Department
- Financial Operations
- Health Ministries
- St. John's Healthcare Foundation (Oxnard and Pleasant Valley)
- St. John's Medical Staff
- Strategic Planning/Business Development
- Healthy Beginnings Program staff

St. John's leadership has determined our primary foci are growth, quality, and physician integration as the areas that are critical to the organization's success in accomplishing its mission, including (1) working with community leadership to develop programs that address disproportionate unmet health needs, (2) addressing unmet health needs by developing new

ways to effectively break down barriers to care in our communities, and (3) extending our advocacy role to improve everyone's access to healthcare.

St. John's 2011 – 2012 strategy, as it relates to the community, calls for St. John's to continue to enhance and expand access and services to persons with disproportionate unmet healthcare needs through programs such as our obesity prevention and diabetes mellitus initiatives. It also calls for continuing our team approach as we collaborate to develop, implement, and evaluate our community benefit efforts through a team that includes members from St. John's hospital leadership, physicians, and nurses; allied healthcare providers; and community agencies and community members.

St. John's Community Board reviews, approves, and offers broad based support for the community health activities of St. John's. The board, representing a cross-section of the community, has members from a wide spectrum of businesses and community based organizations in the hospitals' service area. Possessing a thorough understanding of the top five healthcare needs that emerged from the 2009 community needs assessment, St. John's Foundation is instrumental in supporting funding to sustain community health improvement initiatives and St. John's Executive Leadership and Community Board are essential in reviewing and approving budgeting decisions, program content, program design, program targeting, continuation, termination, monitoring and oversight.

Developing St. John's Community Benefit Report and Plan

St. John's Community Benefit Programs are continually reviewed throughout the year using the strategic objectives established by St. John's Executive Leadership; CHW, recent community needs assessment data, and perceived needs of the community as identified by St. John's Community Relations/Benefits Committee. Additionally, the Advancing the State of the Art in Community Benefit (ASACB) principles are reference tools used to develop and maintain standardized reporting, and review templates as reflected in the Program Digests on pages 18-25. These standards establish criteria for charitable behavior that facilitate institutional engagement, demonstrate alignment with charitable mission, strategic planning and increase accountability for performance in the community benefit.

How Will the Community Benefit Report/Plan be shared?

The St. John's Community Benefit Report is made available to the community in both English and Spanish, and disseminated at presentations, meetings, online (www.stjohnshealth.org), community events, and via newsletter mailings.

Core Principles

Five Core Principles provide the framework to guide the selection and prioritization of community benefit activities and provide for a comprehensive review of community benefit programs. The Core

Principles will provide the framework for Tier I – III program digests. The core principles include:

1. Emphasis on Disproportionate Unmet Health-Related Needs (DUHN) – Seek to respond to those communities/neighborhoods with disproportionate unmet health-related needs. The program must include outreach mechanisms and program design elements that ensure access to residents within DUHN communities.

2. Emphasis on Primary Prevention – Address the underlying causes of persistent health problems through health promotion, disease prevention and health protection.
3. Build a Seamless Continuum of Care – Emphasize development of evidence-based links between clinical services and community-based services/activities.
4. Build Community Capacity – Target resources to mobilize and build the capacity of existing community assets.
5. Emphasis on Collaborative Governance – Engage diverse community stakeholders in the selection, design, implementation and evaluation of program activities.

Community Benefit Program Review Findings

This overview summarizes the concepts and processes used to review St. John’s community benefit programs, the findings from the review, and the factors that will help focus our community benefit strategy to make efficient and appropriate use of our limited charitable resources.

As a result of a comprehensive community benefit program review, St. John’s Hospitals have established baseline activities and identified proposed program enhancements. These programs have been further prioritized by placing them in tiers. These tiers indicate a level of needed attention and resources. Tier I programs will focus additional hospital and community resources in order to effectively address community need. Tier II programs can successfully meet goals and core principle enhancements with limited resources and few new resources. Tier III programs can maintain activities “as is” as they are satisfactorily addressing their intended purposes.

Tier I

- Diabetes Programs (General)
- Hospital Admission Readmission Reduction Programs
- Chronic Disease Self Management
- Diabetes Case Management
- CHF Self Management
- Youth Obesity Prevention Programs
- Mobile Health Clinic Outreach

Tier II

- Heart Services
- St. John’s Cancer Center of Ventura County

Tier III

- Parish Health Ministries
- Community Grants
- Healthy Beginnings
- Health Ministries Basic Needs
- Immunization Programs
- Outreach Programs
- Senior Health Connection

By further segmenting our community benefit programs by tiers, we have established priorities for the use of our charitable resources. Most of our programs effectively address their identified purposes and goals and are able to continue their activities with few needed enhancements. Tier II and, most importantly, Tier I programs will require increased resources. Consistent with the CHNA and other national data, diabetes and youth obesity present significant, immediate,

and long-term health risks for the residents of Ventura County, especially for those in the disproportionate unmet health needs (DUHN) populations. Establishing the programs that address these risks and community needs as high priorities gives us a clear strategy for action as we move forward and emphasize community health improvement and help reduce the demand for high cost medical care.

Reducing Health Disparities

Consistent with the Affordable Care act, CHW's Horizon 2020 calls our hospitals to decrease inpatient readmissions for ambulatory care sensitive conditions upon completion of a Chronic Disease Self Management Program (CDSMP) for a period of at least six months. Baseline data will follow establishment of this chronic disease self management workshop series. Hospital Admission Readmission Reduction Program (HARR): Strategic goals and objectives by CHW align with those in the most recent community needs assessment, and were the basis for the recommended goal to reduce hospital utilization by program participants in a selected cohort through active participation in a preventive health intervention. St. John's has identified diabetes and obesity (as a precursor to diabetes as well as other chronic diseases), as the high priority health issues in our communities on which we will focus our greatest efforts. As such, St. John's has maintained a steadfast community focused campaign to decrease uncontrolled diabetes admission rates of identified participants in specified preventive health interventions by five percent.

Specifically, the goals for the youth obesity and diabetes programs are:

- Reduce obesity among youth.
- Decrease disease complications associated with obesity.
- Identify individuals in the community with diabetes and intervene to prevent further diabetes related complications.
- Provide people with diabetes the support, knowledge and resources to manage their diabetes and to delay the development of the disease.
- Decrease ED and/or hospital utilization as a result of preventive health interventions for diabetes.

Specific enhancements for each program have been identified that will support achievement of these program goals. Notably, the programs have engaged additional community partners to increase community capacity for diabetes and youth obesity interventions, initiated a community based case management program for our diabetes patients, and established appropriate measurement strategies to meet our system-wide goal to decrease hospital utilization of program participants with diabetes mellitus.

Congestive Heart Failure has also been identified as an Admission/Readmission priority. The evidence based proven CHAMP® program, from the Mercy Heart and Vascular Institute, will be utilized to assist Congestive Heart Failure (CHF) patients & community members to avoid admissions/reduce readmissions and thus improve the quality of life for those who suffer from CHF by empowering them to gain knowledge and better control of their chronic disease. This is achieved through: Education about: the disease processes & symptoms, nutrition, medications and activity. As this new program rolls out, during 2012 we will:

- Educate physicians about the value of the program
- Identify those most likely to benefit (un/under insured not residing in a facility)
- Create a process for referral and enrollment that is comprehensive.

Planning for the Uninsured/Underinsured Patient Population

Using the ASACB program review guidelines, every St. John's program offering was assessed with respect to its effectiveness in reaching populations with disproportionate unmet health-related needs (DUHN). The Program Updates and Report found in the next section of this report demonstrate St. John's focus on providing for the uninsured and underinsured patient populations in our service areas.

Additionally, St. John's has a Financial Counseling and Assistance Policy (ARI-01 which may be viewed at http://stjohnsmore.chw.edu/images/d/db/ARI-01_Financial_Counseling_8-08.pdf and in accordance with that policy financial assistance information is given to all patients. Financial Counseling is available which informs and assists patients with seeking government or third party payment, and/or a discount. A Payment Assistance Policy (ARI-03) also provides relief for those seeking to pay over time http://stjohnsmore.chw.edu/images/5/58/ARI-03_Payment_Assistance%2C_Uninsured_Patient_Billing_and_Collections_Guidelines_3-10.pdf

Information about the patient financial assistance policy is presented to all patients upon admission, during free screening clinics, and made available at support groups in which DUHN community members participate. It is also reinforced at management council meetings and related St. John's staff functions.

PLAN REPORT AND UPDATE INCLUDING MEASURABLE OBJECTIVES AND TIMEFRAMES

Programs have been developed to address key issues. These programs are continuously monitored for performance and quality with ongoing improvements to facilitate their success. The Community Benefit Committee, Executive Leadership, the Community Board and Catholic Healthcare West receive quarterly updates on program performance and news.

The following pages include Program Digests for a few key programs that address one or more of the Initiatives listed above.

CONGESTIVE HEART FAILURE (CHF) PROGRAM (NEW PROGRAM FOR 2012)	
Hospital CB Priority Areas	<ul style="list-style-type: none"> ✗ Availability, access, and cost of healthcare services ✗ Chronic disease management, prevention and education <input type="checkbox"/> Women's health services <input type="checkbox"/> Adult and children's immunizations <input type="checkbox"/> Children and Youth Health and Wellness
Program Emphasis	<ul style="list-style-type: none"> ✗ Disproportionate Unmet Health-Related Needs ✗ Primary Prevention ✗ Seamless Continuum of Care ✗ Build Community Capacity <input type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	This program is open to all community members with congestive heart failure at no cost, including the poor and underserved.
Program Description	SJRMHC & SJPVH are committed to reducing hospital re-admissions of Congestive Heart Failure (CHF) community members by identifying and recruiting candidates for the Congestive Heart Failure Program. The Congestive Heart Failure Program provides education to patients diagnosed with CHF during the hospital stay in addition to providing discharge instructions. This program provides education, risk assessment and referrals to CHF patients. The CHF Program is a multipronged approach 1) Home Health follow-up, 2) Cardiac Rehab and 3) CHAMP®. Nurses evaluate CHF patients and recommend they participate in one or more of the program's levels based on appropriateness. Patients enrolled in CHAMP® are provided consistent telephone follow-up and education, thereby decreasing the number of readmissions to the hospital. In addition, the CHF program participants are referred to the Chronic Disease Self-Management Program.
FY 2012	
Goal FY 2012	<p>Primary Goal:</p> <ul style="list-style-type: none"> • Participants in the Congestive Heart Failure Program will avoid re-admissions to the hospital within 30 days. <p>Secondary Goal:</p> <ul style="list-style-type: none"> • The hospital will increase the number of patients enrolled in the CHAMP® program.
2012 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • 40% of the participants enrolled in CHAMP® will not be re-admitted to the hospital within 30 days. • Enroll 100 participants in CHAMP®. • Refer to CHAMP® all appropriate patients.
Baseline	<p>FY 2011:</p> <ul style="list-style-type: none"> • 67% of the CHF appropriate patients were not re-admitted to the hospital within 30 days. • 64 participants were enrolled in CHAMP®.

Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> • Provide on-going education for staff and healthcare providers about the value of the CHF Program. • Work with the Mercy Health & Vascular Institute to provided consistent telephone follow-up and education to patients enrolled in CHAMP®. • CHF team will conduct regular meetings to identify strategies to increase program enrollment. • Identify CHF program candidates and refer to the appropriate program level. • Provide discharge planning, CHF symptom management education, home health service evaluation and referral to the appropriate resources. • Provide follow-up visits, assessments and education to CHF participants. • Refer and enroll patients to Living Well: Chronic Disease Self-Management Program and conduct program.
Community Benefit Categories	Community Health Improvement Services

SENIOR WELLNESS PROGRAM	
Hospital CB Priority Areas	<ul style="list-style-type: none"> ✗ Availability, access, and cost of healthcare services ✗ Chronic disease management, prevention and education ☐ Women’s health services ✗ Adult and children’s immunizations ☐ Children and Youth Health and Wellness
Program Emphasis	<ul style="list-style-type: none"> ✗ Disproportionate Unmet Health-Related Needs ✗ Primary Prevention ✗ Seamless Continuum of Care ✗ Build Community Capacity ✗ Collaborative Governance
Link to Community Needs Assessment	Senior citizens make up 12% of the population, with the number of seniors predicted to increase over the next ten years.
Program Description	The Senior Wellness Program has been an integral part of St. John’s Community Health Education Department for 25 years. The Senior Wellness Program consists of programs that aim to provide seniors with tools to improve their health and wellness. In the past, seniors have been able to participate in the following programs: Energizer’s Walking Program, English and Spanish support groups; Spanish-language exercise classes, Chronic Disease Management classes and other health education classes, health screenings, bone builders classes, flu and pneumonia clinics, mature driver safety classes, Health Insurance Counseling and Advocacy Program, wellness lectures, and wellness clinics offered at three senior centers. Blood pressure and blood glucose screenings are offered during the wellness clinics and the Energizer’s Walking Program. In addition, HbA1C screenings are offered to all participants who have diabetes.
FY 2011	
Goal 2011	<ul style="list-style-type: none"> • Monitor and manage hypertension and diabetes among seniors • Prevent a medical crisis and hospitalization through early referral. • Improve health and wellness of seniors.
2011 Objective Measure/Indicator of Success	<p>90% of program clients will NOT have a critical value on blood pressure level.</p> <p>90% of program clients will NOT have a critical value on blood sugar levels.</p> <p>Senior Health Connection program participants will display a 5% increase in knowledge of disease management and health wellness as demonstrated in pre-and post-tests.</p> <p>75% of Walking Program participants with diabetes will achieve an HbA1C level below 7.0% by the end of the year.</p>
Baseline	<p>FY 2010:</p> <p><1% (1 out of 1,877 screenings) of program clients had a blood pressure critical value (above 180/110).</p> <p>< 3% (3 out of 760 screenings) of program clients had a blood glucose critical</p>

	<p>value (above 300 mg/dl).</p> <p>22% increase in knowledge for the participants of the Diabetes Management classes offered by the Senior Health Connection program.</p> <p>100% of Walking Program participants with diabetes with an HbA1C below 7% at the beginning of the year maintained their HbA1C level below 7.0% throughout the year.</p> <p>From all the participants of the Walking Program with diabetes 78% reported an HbA1C level below 7.0% at the end of the year.</p>
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> Utilize 2009 Community Needs Assessment to plan, organize and coordinate increased outreach to DUHN communities and measure effectiveness of interventions. Enroll participants with diabetes who have HbA1C test results above 7.0%.
Result FY 2011	<p>* 2 (.0006%) out of 3,427 blood pressure screenings of program clients had a critical value blood pressure (above 180/110).</p> <p>* 5 (.002%) out of 1,920 blood sugar screenings of program clients with diabetes had a critical value blood glucose (above 300 mg/dl).</p> <p>10% increase in knowledge in health and disease management classes measured by pre and post test.</p> <p>75% of Walking Program participants with diabetes maintained throughout the year an HbA1C level below 7.0%.</p> <p>Additionally, the Senior Wellness Program provided the following:</p> <ul style="list-style-type: none"> * 4,790 contacts in walking program * 235 persons attended Eng. Diabetes Education and Support group meetings * 93 persons attended Spanish Diabetes Support Group * 471 received flu immunizations * 141 received pneumonia immunizations * 3,427 blood pressure screenings * 1,920 blood glucose screenings * 475 received group Health Education * 1,165 attended exercise classes * 318 attended health fairs (information and referral)
Hospital's Contribution / Program Expense	<p>Support for this program was included in St. John's Operational Budget. St. John's offers hospital conference rooms to Bone Builders Class and Health Insurance Counseling and Advocacy Program and applied the cost to community benefit. St. John's Auxiliaries and Golden Classics collaborated with the community health education department staff to offer free health screenings, health information, assistance with walking program and flu and pneumonia shots.</p>
FY 2012	
Goal 2012	<ul style="list-style-type: none"> Monitor and manage hypertension and diabetes among seniors. Prevent a medical crisis and hospitalization through early referral. Improve health and wellness of seniors.
2012 Objective Measure/Indicator of Success	<p>90% of program clients will NOT have a critical value on blood pressure level.</p> <p>90% of program clients will NOT have a critical value on blood sugar levels.</p> <p>Senior Wellness Program participants will display a 5 % increase in knowledge of health and disease management as demonstrated in pre-and post-tests.</p> <p>75% of Walking Program participants with diabetes will achieve an HbA1C level below 7.0% by the end of the fiscal year.</p>
Baseline	<p>FY 2011:</p> <ul style="list-style-type: none"> * 2 (.0006%) out of 3,427 blood pressure screenings of program clients had a blood pressure critical value (above 180/110). * 5 (.002%) out of 1,920 blood sugar screenings of program clients with diabetes had a blood glucose critical value (above 300 mg/dl). <p>10% increase in knowledge in health and disease management classes measured by pre and post test.</p> <p>75% of Walking Program participants with diabetes maintained throughout the year an HbA1C level below 7.0%.</p>
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> Utilize 2009 Community Needs Assessment to plan, organize and coordinate increased outreach to DUHN communities and measure effectiveness of interventions.

	<ul style="list-style-type: none"> • Enroll participants in program, provide interventions and monitor their blood pressure and blood sugar. • Refer participants to the Chronic Disease Self Management Program.
Community Benefit Categories	A1-a Community Health Education – Lectures/Workshops A1-c Community Health Education – Individual Health Education A1-d Community Health Education – Support Groups A1-e Community Health Education - Self-help A2-d Community Based Clinical Services – Immunizations/Screenings

YOUTH OBESITY PREVENTION PROGRAM	
Hospital CB Priority Areas	<ul style="list-style-type: none"> ✗ Availability, access, and cost of healthcare services ✗ Chronic disease management, prevention and education ☐ Women’s health services ☐ Adult and children’s immunizations ✗ Children and Youth Health and Wellness
Program Emphasis	<ul style="list-style-type: none"> ✗ Disproportionate Unmet Health-Related Needs ✗ Primary Prevention ☐ Seamless Continuum of Care ✗ Build Community Capacity ✗ Collaborative Governance
Link to Community Needs Assessment	This initiative addresses the identified unmet community health need for disease management and youth obesity prevention. Ventura County has seen a rise in youth obesity rates from 19% in 2005 to 23.9% in 2006 in low-income children between the ages of 5 and 19, particularly in the Latino/Hispanic population of Oxnard, California, in the key zip codes of 93030, 93033, 93031, and 93036 and in Camarillo in the zip code of 93010. ***Included in 2009 CNA
Program Description	The Youth Obesity Prevention Program educates youth and their parents about healthy nutrition, and physical activity through several hospital-based community classes and collaborative activities including the Starting Healthy Activities and Physical Education (SHAPE), and Eating Smart for Kids programs.
FY 2011	
Goal 2011	<ul style="list-style-type: none"> • Reduce obesity among youth • Decrease disease complications associated with obesity
2011 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • 5% increase in nutrition knowledge among youth in child nutrition programs • 5 % increase in physical activity among youth as self reported from parent/youth program surveys • 10% increase in healthy food choices and physical activity among youth
Baseline	Pre-course levels of physical activity and food choices among youth as self reported.
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> • Continue expanding partnerships with El Rio/Oxnard School District, Pleasant Valley School District, Boys and Girls Club of Camarillo to increase curriculum into schools within key zip codes for youth at most risk for obesity. • Increase partners in surrounding communities of St. John’s Regional and St. John’s Pleasant Valley to provide for youth screenings & education. • Implement our outreach youth obesity classes, screenings, and collaborate with local school districts and health and fitness programs.
Result FY 2011	<ul style="list-style-type: none"> • 86% increase in nutrition knowledge among youth in child nutrition programs • 86% increase in physical activity among youth as self reported from parent program surveys. • 86% increase in healthy food choices among youth - self reported from parent program surveys.

Hospital's Contribution / Program Expense	Support for this program was included in St. John's Operational Budget (\$370K). In addition, St. John's works very closely with community schools and local organizations.
FY 2012	
Goal 2012	Integrate the Youth Obesity Prevention Classes to the into the Diabetes Prevention Programs.
Community Benefit Category	A1-Community Health Education Lectures/Workshops.

CHRONIC DISEASE SELF MANAGEMENT PROGRAM (CDSMP)

Hospital CB Priority Areas	<input checked="" type="checkbox"/> Availability, access, and cost of healthcare services <input checked="" type="checkbox"/> Chronic disease management, prevention and education <input type="checkbox"/> Women's health services <input type="checkbox"/> Adult and children's immunizations <input type="checkbox"/> Children and Youth Health and Wellness
Program Emphasis	<input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input checked="" type="checkbox"/> Build Community Capacity <input type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	Community-based CDSMP programs have the potential to improve the lives of the local community with pre-existing chronic illness while reducing emergency room use and complications due to unmanaged illness.
Program Description	The Chronic Disease Self-Management Program is a workshop given two and a half hours, once a week, for six weeks, in community settings such as senior centers, churches, libraries and hospitals. People with different chronic health problems attend together. Workshops are facilitated by two trained leaders. Subjects covered include: 1) techniques to deal with problems such as frustration, fatigue, pain and isolation; 2) appropriate exercise for maintaining and improving strength, flexibility, and endurance; 3) appropriate use of medications; 4) communicating effectively with family, friends, and health professionals; 5) healthy nutrition; and 6) how to evaluate new treatments.

(Baseline Year) FY 2011 (Baseline Year)

Goal 2011	<ul style="list-style-type: none"> • Prevent /reduce hospital and/or emergency room admissions. • Prevent medical complications, crisis and/or adverse outcomes. • Improve health and wellness of community members affected by one or more chronic disease. • Promote healthy lifestyles. • Provide strategies to support opportunity and improvement. • Promote teamwork, creative problem solving and innovation.
2011 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • 75% of program participants will avoid readmission for 6 months after completion of CDSMP. • 75% of program participants will demonstrate fewer physician visits for 6 months following completion of a CDSMP. • 40-50 community members with a chronic disease will complete a Healthier Living Series. • 75% of program participants will increase Healthy Behaviors. (As self reported) • 90% of program participants reported increased health and coping strategies.
Baseline	<p>In FY2010 the following baseline results for CDSMP participants were reported after completion of one (1)CDSMP series :</p> <ul style="list-style-type: none"> • 12 participants completed one Stanford CDSMP (Healthier Living series) • Zero readmissions of all program participants 90 days following the completion of CDSMP <p>Additionally, the following baseline outcomes and measures were reported:</p>

	<ul style="list-style-type: none"> * 92% of program participants reported an improvement in healthy behaviors following a CDSMP * 90% of program participants reported fewer related physician visits following completion of a CDSMP * 90% of program participants reported increased healthy behaviors following completion of a CDSMP
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> • Utilize 2009 Community Needs Assessment to plan & implement increased outreach to DUHN communities and those affected by chronic disease • Institute measures for health related outcomes specific to program objectives by increasing additional partners (health insurance companies, Camarillo Healthcare District, Ventura County Area Agency on Aging, Ventura County Public Health District, and Local Senior Centers) • Develop enhanced intervention strategies with major community health partners.
Results FY 2011	<ul style="list-style-type: none"> • 86% of program participants were not hospitalized for 6 months after completion of CDSMP. • 43% of program participants reported fewer physician visits due complications for 6 months following completion of a CDSMP. • 23 community members with a chronic disease completed a CDSMP. • 86% of program participants increased healthy behaviors. (As self reported) • 100% of program participants obtained the skills on how to perform coping strategies to improve their health and to manage their chronic illness. (As self reported by participants who completed the Program Evaluation) • 77% of program participants' health was improved as a result of participating in the CDSMP. (As self reported by participants who completed the Program Evaluation)
Hospital's Contribution / Program Expense	Support for this program was included in St. John's Operational Budget. (\$429k). St. John's utilizes hospital space (St. John's Conference Rooms) for meetings, support groups and related chronic disease events in support of reducing readmissions due to complication and unmanaged chronic illness. Additionally, St. John's Community Grants program awarded over \$145k in community grants to areas agencies and organizations committed to address health disparity and the reduction of complications due to limited access and/or economic barriers to healthcare.
FY 2012	
Goal 2012	Integrate the Chronic Disease Self Management Program into the Diabetes Program, and hospital and emergency department readmissions reduction programs, and report outcomes under existing outreach specific program's digests.
Community Benefit Category	A1-a Community Health Education – Lectures/Workshops

DIABETES HOSPITAL ADMISSION READMISSION REDUCTION PROGRAM	
Hospital CB Priority Areas	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Availability, access, and cost of healthcare services <input checked="" type="checkbox"/> Chronic disease management, prevention and education <input checked="" type="checkbox"/> Women's health services <input type="checkbox"/> Adult and children's immunizations <input type="checkbox"/> Children and Youth Health and Wellness
Program Emphasis	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input checked="" type="checkbox"/> Build Community Capacity <input type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	St John's 2009 Community Needs Assessment and corresponding Community Needs Index (CNI) Support the CHW Horizon 2010 Initiative in the area of addressing the DUHN of the High risk for undiagnosed and/or under-treated type 2 diabetes among the Latino Hispanic population of Oxnard, California, in the key zip codes of 93030, 93033, 93035, 93036, and 93041, and Camarillo in the zip code of 93010, and 93012.
Program Description	SJRCM & SJPVH are committed to reducing the complications, and associated hospital readmissions of type 2 diabetic community members, by identifying and recruiting a

	<p>combined cohort from both hospitals of 50-75 community members diagnosed with diabetes interested in preventing further hospitalization due to complications that may arise from unmanaged, or uncontrolled diabetes. In addition to preventing hospital admission, the following related secondary outcomes measures will also benefit program participants:</p> <table border="1"> <thead> <tr> <th>SHORT TERM</th> <th>LONG TERM</th> </tr> </thead> <tbody> <tr> <td>Glycemic Control</td> <td>Morbidity</td> </tr> <tr> <td>Blood Pressure</td> <td>Mortality</td> </tr> <tr> <td>Lipid/Cholesterol levels</td> <td>Quality of Life</td> </tr> <tr> <td>Body Mass index</td> <td>Economic factors (assoc w/ cost of Treatment)</td> </tr> </tbody> </table>	SHORT TERM	LONG TERM	Glycemic Control	Morbidity	Blood Pressure	Mortality	Lipid/Cholesterol levels	Quality of Life	Body Mass index	Economic factors (assoc w/ cost of Treatment)
SHORT TERM	LONG TERM										
Glycemic Control	Morbidity										
Blood Pressure	Mortality										
Lipid/Cholesterol levels	Quality of Life										
Body Mass index	Economic factors (assoc w/ cost of Treatment)										
FY 2011											
Goal FY 2011	<p>Primary Goal:</p> <ul style="list-style-type: none"> Reduce hospital admission due to preventable diabetes complications by 5% in a selected cohort of 50-75 program participants during a 6 month period. <p>Secondary Goal:</p> <ul style="list-style-type: none"> Reduction of HbA1C levels, with goal of reaching normal ranges (under 7.0%). Reduction in Blood Pressure, with goal of reaching normal ranges (< 130/80). Increase attendance at support group or educational offerings. Increase in physical activity events per month. Self-identified % increase in overall general health and well being. 										
2011 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> 5% reduction of hospital admissions due to preventable diabetes complications and uncontrolled diabetes for program participants. 5% reduction of HbA1C levels for program participants with values outside normal ranges ($\geq 7.0\%$). 5% reduction in Blood Pressure values for program participants with results outside normal ranges ($\geq 130/80$). 5% increase in participant physical activity (As self reported). 										
Baseline	<p>FY 2010:</p> <ul style="list-style-type: none"> 98% reduction of hospital admission due to preventable diabetes complications and uncontrolled diabetes for program participants. 11.22% Reduction HbA1C levels for program participants with levels outside normal ranges ($\geq 7.0\%$). 6% reduction in systolic blood pressure for the individuals with systolic blood pressure with levels outside the normal ranges, and 8% reduction of the diastolic blood pressure for the participants with a systolic blood pressure with levels outside normal ranges ($\geq 130/80$). 1.3% Reduction of body weight for program participants within the overweight/obese category. (58% of the participants within the overweight/obese category had a weight reduction.) 7% Increase in participant physical activity (As self reported). 										
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> Identify and recruit a cohort of 50-75 HARR program participants. Provide enhanced diabetes related preventative and screening programs. 										
Results FY 2011	<ul style="list-style-type: none"> 94% reduction of hospital admissions due to preventable diabetes complications and uncontrolled diabetes for program participants. 8% reduction of HbA1C levels for program participants with baseline levels outside normal ranges ($\geq 7.0\%$). 9% reduction in systolic blood pressure for the program participants with systolic blood pressure values outside the normal ranges, and 13% reduction of diastolic blood pressure for the participants with values outside normal range ($\geq 130/80$). 21% increase in participant physical activity (As self reported). <p>Additionally the following results are reported:</p> <ul style="list-style-type: none"> 969 screenings and services were provided to the program participants. 121 HbA1C screenings 										

	<ul style="list-style-type: none"> • 100 Lipid panels • 99 Blood Glucose screenings • 100 Blood Pressure screenings • 9 BMI measurements • 448 individual and group education encounters • 45 eye and foot screenings
Hospital's Contribution / Program Expense	Support for the Diabetes Hospital Admission Readmission Reduction Program was included in St. John's Operational Budget.
FY 2012	
Goal FY 2012	<p>Primary Goal:</p> <ul style="list-style-type: none"> • Participants in the Diabetes Horizon 2013 program will avoid re-admissions to the hospital or the ER due to preventable diabetes complications for 6 a months period following program intervention. <p>Secondary Goal:</p> <ul style="list-style-type: none"> • Reduction HbA1C levels, with goal of reaching normal ranges (under 7.0%). • Reduction in Blood Pressure, with goal of reaching normal ranges (< 130/80). • Self-identified % increase in overall general health and well being.
2012 Objective Measure/Indicator of Success	<ul style="list-style-type: none"> • 50% of the participants in hospital intervention program will not be admitted to the hospital/ER within six month of the intervention due to preventable diabetes complications and uncontrolled diabetes. • 5% reduction HbA1C levels for program participants with levels outside normal ranges ($\geq 7.0\%$). • 5% reduction in Blood Pressure values for program participants with values outside normal ranges ($\geq 130/80$). • 5% increase in participant physical activity. (As self reported).
Baseline	<ul style="list-style-type: none"> • 100% of the participants in the cohort reported a hospital admission at the beginning of the program. • HbA1C and blood pressure baseline values of the participants are determined during the first assessment of the fiscal year. • Baseline physical activity level of the cohort is determined by the initial diabetes behavioral assessment results as self reported. <p>Baseline data includes results from FY11:</p> <ul style="list-style-type: none"> • 94% reduction of hospital admission due to preventable diabetes complications and uncontrolled diabetes for program participants. • 8% reduction HbA1C levels for program participants with levels outside normal ranges ($\geq 7.0\%$). • 9% reduction in systolic blood pressure for the program participants with systolic blood pressure values outside the normal ranges and 13% reduction in diastolic blood pressure for the participants with diastolic blood pressure values outside normal ranges ($\geq 130/80$). • 21% increase in participant physical activity. (As self reported).
Intervention Strategy for Achieving Goal	<ul style="list-style-type: none"> • Identify and recruit program participants. • Provide diabetes education and screening programs. • Refer participants to the Chronic Disease Self Management Program.
Community Benefit Categories	A1-a Community Health Education – Lectures/Workshops A1-c Community Health Education – Individual Health Education A2-d Community Based Clinical Services – Immunizations/Screenings

Summary of Benefit Expense

Through these programs, and other non-programmatic efforts, the total value of community benefit by St. John's Hospitals for FY2011 is \$64,298,033 which excludes the unpaid costs of Medicare of \$34,497,905. Combined, the unsponsored community benefit expenses totaled \$64,497,905.

381 St. John's Pleasant Valley Hospital Complete Summary - Classified Including Non Community Benefit (Medicare) For period from 7/1/2010 through 6/30/2011

	Persons Served	Expense	Revenue	Benefit	Expenses	Revenues
Benefits for Living in Poverty						
Traditional Charity Care	148	\$530,695	\$0	\$530,695	0.9	0.8
Unpaid Cost of Medicaid	2,445	\$10,945,352	\$5,550,806	\$5,394,546	9.0	8.6
Community Services						
Community Building Activities	0	\$371	\$0	\$371	0.0	0.0
Community Health Improvement Services	2,116	\$48,153	\$0	\$48,153	0.1	0.1
Financial and In-Kind Contributions	27	\$26,185	\$0	\$26,185	0.0	0.0
Totals for Community Services	2,143	\$74,709	\$0	\$74,709	0.1	0.1
Totals for Living in Poverty	4,736	\$11,550,756	\$5,550,806	\$5,999,950	10.1	9.5
Benefits for Broader Community						
Community Services						
Community Benefit Operations	0	\$86,644	\$0	\$86,644	0.1	0.1
Community Building Activities	737	\$2,510	\$0	\$2,510	0.0	0.0
Community Health Improvement Services	1,601	\$13,313	\$0	\$13,313	0.0	0.0
Totals for Community Services	2,338	\$102,467	\$0	\$102,467	0.2	0.2
Totals for Broader Community	2,338	\$102,467	\$0	\$102,467	0.2	0.2
Totals - Community Benefit	7,074	\$11,653,223	\$5,550,806	\$6,102,417	10.2	9.7
Unpaid Cost of Medicare	13,981	\$39,653,096	\$26,976,354	\$12,676,742	21.3	20.1
Totals including Medicare	21,055	\$51,306,319	\$32,527,160	\$18,779,159	31.5	29.8

383 St. John's Regional Medical Center - Oxnard Complete Summary - Classified Including Non Community Benefit (Medicare) For period from 7/1/2010 through 6/30/2011

	Persons Served	Expense	Revenue	Benefit	Expenses	Revenues
Traditional Charity Care	1,261	\$2,851,641	\$0	\$2,851,641	1.5	1.5
Unpaid Cost of Medicaid	21,740	\$58,268,690	\$39,098,255	\$19,170,435	10.4	9.8
Community Services						
Community Benefit Operations	0	\$8,619	\$0	\$8,619	0	0
Community Building Activities	0	\$495	\$0	\$495	0	0
Community Health Improvement Services	34,235	\$459,495	\$298	\$459,197	0.2	0.2
Financial and In-Kind Contributions	44,006	\$748,937	\$3,773	\$745,164	0.4	0.4
Health Professions Education	24	\$1,587	\$0	\$1,587	0	0
Totals for Community Services	78,265	\$1,219,133	\$4,071	\$1,215,062	0.7	0.6
Totals for Living in Poverty	101,266	\$62,339,464	\$39,102,326	\$23,237,138	12.6	11.8
Benefits for Broader Community						
Community Services						
Community Benefit Operations	0	\$299,002	\$0	\$299,002	0.2	0.2
Community Building Activities	1,001	\$6,436	\$0	\$6,436	0	0
Community Health Improvement Services	12,409	\$148,662	\$120	\$148,542	0.1	0.1
Financial and In-Kind Contributions	283	\$6,656	\$0	\$6,656	0	0
Totals for Community Services	13,693	\$460,756	\$120	\$460,636	0.2	0.2
Totals for Broader Community	13,693	\$460,756	\$120	\$460,636	0.2	0.2
Totals - Community Benefit	114,959	\$62,800,220	\$39,102,446	\$23,697,774	12.8	12.1
Unpaid Cost of Medicare	14,105	\$88,704,428	\$66,883,328	\$21,821,100	11.8	11.1
Totals including Medicare	129,064	\$151,504,648	\$105,985,774	\$45,518,874	24.7	23.2

Community Benefit expenses are derived using a cost accounting methodology.

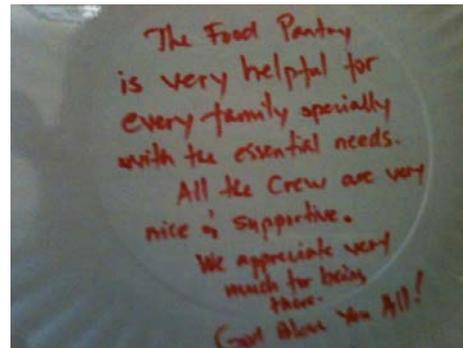
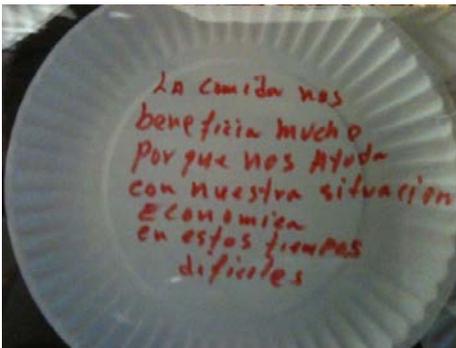
Non-quantifiable Benefits

The hospital environment favors programs that are driven by outcomes and validated evidence based activities. Community Benefit, however, often involves the intangible impact—those we touch who express a feeling of being less marginalized, seeing expressions on those we help that indicated raised hope in people, finding others who are eager to help make our communities a better place to live, improving the quality of life sometimes one person at a time or in something as simple as the smile of a child receiving a new pair of shoes.

Below is a pictorial, non-quantifiable story. The first photograph is a day in the life of our food pantry--the picking-up food, stocking, the organizing and then the distribution to so many families in need.



The second and third photographs are paper plates, left behind by some of the grateful people that we serve:



These tell the story of lives touched in ways that cannot be quantified—of hope freely given in a time of need improving the quality of life for those at risk—and work that goes on week after week, assisted by members of our community to improve the wellness of our communities. The pantry also helped build character this past year in that two young men from Camarillo earned their Eagle Scout status by renovating and upgrading our Healthy Food Pantry.

Another significant non-quantifiable activity is St. John's monthly Networking Meeting for human service agencies and other public and private community benefit type agencies in Ventura County to share stories, network resources and discuss programs to avoid duplication and maximize use. These meetings routinely draw 30+ people with open hearts and dedicated spirits and the information shared touches so many that cannot be counted.

Telling Our Story

St. John's Hospitals are committed to soliciting feedback and meaningful information from the communities we serve to assist in developing goals for our Community Benefit plan. To that end, St. John's collaborates with organizations in Ventura County to identify those areas of greatest need and opportunity for involvement. The Community Benefit Plan itself is shared and/or publicized:

- With our Community and Foundation Boards
- At presentations and meetings (such as our monthly Networking meeting described above)
- Online (at www.stjohnshealth.org) and on our 'physicians only' web page
- At community events (health fairs, etc.)
- Through our Newsletter (SJH—St. John's Health) which is mailed to residents in the area
- With every CHW Community Grants information request.
- To local care health professional organizations (e.g. physician and nursing organizations)
- In an e-mail to all hospital staff and to our Auxiliary leadership
- And, copies will be available at each hospital through the "Administration and Community Education offices.

Through this dissemination we hope to create dialogue that will lead to program expansion and improvement.

Appendix A

List of Community Board Members 2011-2012:

Suzanne Chadwick (VP Banking)

Margaret Cortese (Clinical Psychologist)

+Laurie Eberst (CHW VP Operations & CEO)

David Edsall Esq. (Attorney & Foundation Chair)

Thomas Holden O.D. (Mayor of Oxnard)

+Colleen House (Retired Dir. of Ventura County Area Agency on Aging)

+Lynn Jeffers MD (Medical Staff)

Ann Kelley MD (Chief of Medical Staff)

+Michael Lavenant Esq. (Attorney)

Christopher Loh MD (Medical Staff)

Laura McAvoy Esq. (Attorney)

Sr. Joanne Marie O'Donnell RSM (Sister of Mercy—sponsor)

Jack Rotenberg MD (Medical Staff)

+Sr. Felice Sauers RSM (Sister of Mercy—sponsor)

+Sylvia Munoz Schnopp (Mayor of Port Hueneme)

+Mart Shum (Community Board Chair & Business Owner)

Donald Skinner (Retired Pres. of a Technology Corp.)

+Anthony Trembley Esq. (Attorney & Chair of Community

Relations/Community Benefits Committee)

Lee Wan MD (Medical Staff)

+Jeri Williams (Chief of Oxnard Police Dept.)

Celina Zacarius (Director, Cal-State Channel Islands Univ.)

(+ indicates member of the Community Relation/Community Benefits Committee)

Appendix B

Community Relations/Community Benefits Committee Organization Plan Fiscal Year 2011

Members

- **From Community Board:** Tony Trembley, Colleen House, Dr. Ann Kelley, Michael Lavenant, Carmen Ramirez, Sister Felice Sauers, Sandy Nirenberg
- **From Administration:** VP Business Development (Leila Yodkovik), VP Mission Integration (George West), Director of Marketing (Frank Austin), CEO (Laurie Eberst)

Vision and Mission

The Community Relations (“CR”) Committee shall be responsible for ensuring a positive and consistent image for the hospitals and an image rooted in St. John’s mission committed to furthering the healing ministry of Jesus and dedicating resources to:

- Delivering compassionate, high-quality, affordable health services;
- Serving and advocating for the sisters and brothers who are poor and disenfranchised; and
- Partnering with others in the community

Foundational expectations include:

- Establish St. John’s Regional Medical Center and St. John’s Pleasant Valley Hospital as the hospitals of choice for Ventura County residents, from all perspectives, including patient, employee, physician and the community; and
- Outreach to our community consistent with our vision and mission, including the provision of community benefits.
- Advocacy as needed on behalf of the hospitals and their communities.

Committee Responsibilities

The Community Relations Committee shall:

1. Monitor compliance with Ethical and Religious Directives for Catholic Health Services and CHW Mission
2. Consider, and where necessary make recommendations on, matters presented to it by the Mission Integration Office
3. Assist in the design of public outreach strategies and strategic marketing programs
4. Review community, press and governmental body relations
5. Advocate

Operations Procedure

On second Monday of each month, the CR Committee shall meet from 5:00 to 6:00 p.m. in the Executive Board Room. The core meeting agenda shall include the following:

- Reports by Senior Management and discussion concerning
 - Compliance and mission integration during the last reporting period

- Status of current community outreach programs
- Status of current press relations
- Status of current government/regulator relations
- Current marketing and future planned marketing
- Advocacy

Roles and Responsibilities

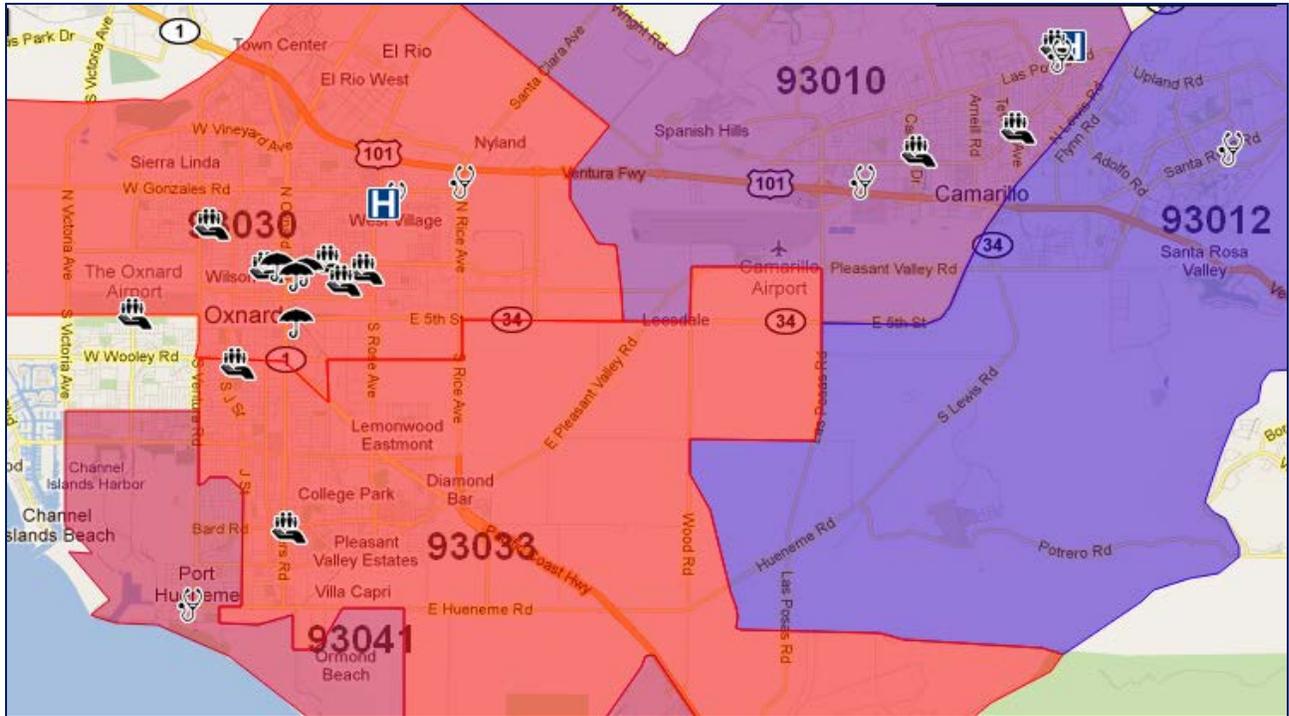
The CR Committee shall elect two officers: a Chairman and a Secretary.

Policy and Resource Guidance:

- CHW Community Board Resource Guide, chapters on community relations
- CHW Governance Policy: community relations
- Ethical and Religious Directives for Catholic Health Care Services

Appendix C

St. John's Pleasant Valley Hospital

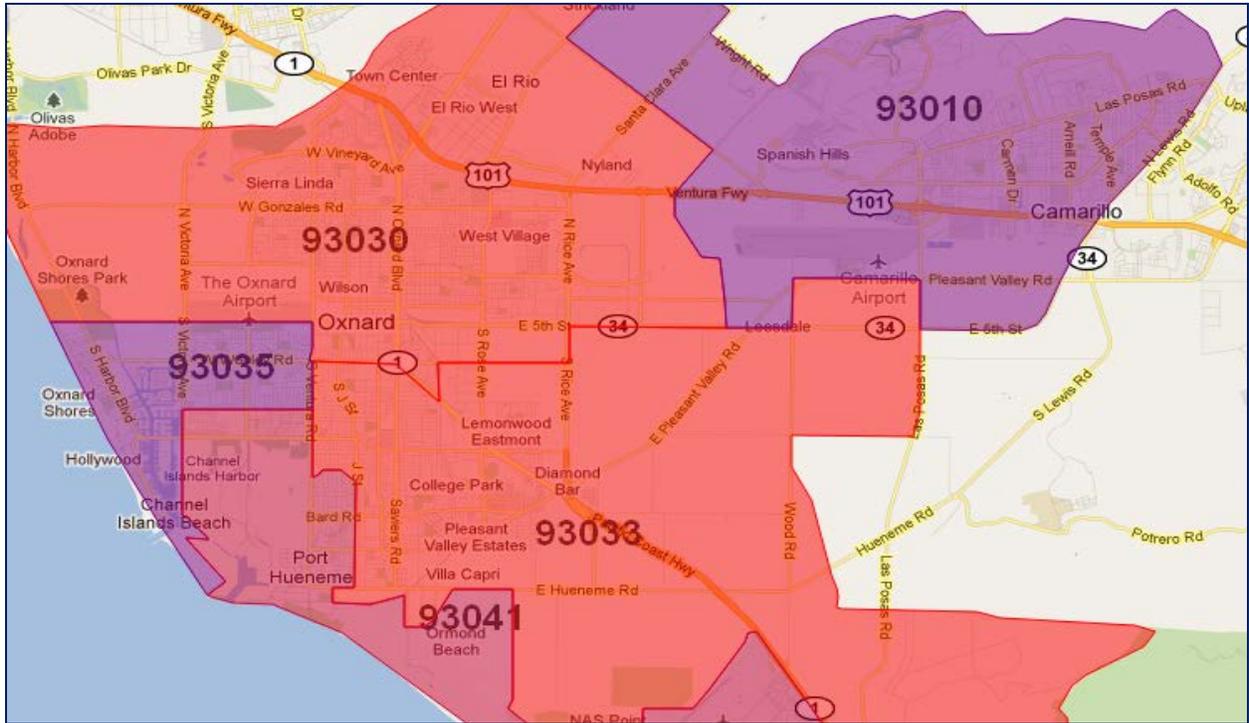


Lowest Need ■ 1 - 1.7 Lowest ■ 1.8 - 2.5 2nd Lowest ■ 2.6 - 3.3 Mid ■ 3.4 - 4.1 2nd Highest ■ 4.2 - 5 Highest **Highest Need**

Zip Code	CNI Score	Population	City	County
93010	2.6	45556	Camarillo	Ventura
93012	2	31468	Camarillo	Ventura
93030	4.4	60354	Oxnard	Ventura
93033	4.2	79283	Oxnard	Ventura
93041	4	23250	Port Hueneme	Ventura

Appendix D

St. John's Regional Medical Center



Lowest Need **Highest Need**
■ 1 - 1.7 Lowest ■ 1.8 - 2.5 2nd Lowest ■ 2.6 - 3.3 Mid ■ 3.4 - 4.1 2nd Highest ■ 4.2 - 5 Highest

Zip Code	CNI Score	Population	City	County
93030	4.4	60354	Oxnard	Ventura
93033	4.2	79283	Oxnard	Ventura
93035	2.8	25669	Oxnard	Ventura
93010	2.6	45556	Camarillo	Ventura
93041	4	23250	Port Hueneme	Ventura